NWX-HHS-AOA-1

Moderator: Lauren Solkowski
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1:00 pm CT

Coordinator: Welcome and thank you all for standing by. At this time all participants are in a listen only mode until the question and answer session of today's call. At that time you can press star 1 to ask a question. I would also like to inform all parties that this call is being recorded. If you have any objections, please disconnect at this time. I would now like to turn today's call over to Ms. Lauren Solkowski. Thank you. Please begin.

Lauren Solkowski: Great. Thank you. And good afternoon everyone and thank you for joining us today for the Administration for Community Living Business Acumen webinar. It's entitled Community Based Organization Impact on Health System Quality and Performance Measures.

This webinar is the second of a three part series focusing on health system quality measures - in particular, how the services and supports provided by community based organizations can help health systems and other integrated care entities meet their quality measures, improve consumer satisfaction and also improve health.

Today's webinar will focus on Medicare star ratings. Again, this is Lauren Solkowski with ACO. And I will be facilitating our webinar. So for today, we have invited Tim McNeill and he is going to be presenting on the star ratings.

So before we begin the presentation, I do have a few housekeeping announcements. So first of which - if you could please use the link that was included in your calendar appointment to get onto WebEx so that you can follow along with the slides.

But that you can also ask your questions when you have them, through the chat function. If you don't have access to the link that was emailed in the appointment, you can also go to www.WebEx.com and click on the attend a meeting button that is located at the top of the page.

And there you can enter the meeting number. So for today, our meeting number is 662380274. Again, that's 662380274. If you are having any additional problems getting onto the WebEx please call the technical support number that is 1 (866) 229-3239. Again, that's 1 (866) 229-3239.

As our operator mentioned, all of the participants are in a listen only mode. However, we do welcome your questions throughout the course of the webinar. And there are two ways that you can ask your questions. As I mentioned earlier, the first is using the chat function is WebEx.

You can type your questions in there. And then I will sort through them and we will get them answered once Tim has finished his presentation. the second way to ask your question, is through the audio line or through the phone.

So when that time comes our operator will provide us with instructions as to how to queue up to ask your question. If there are questions that we do not get

answered during the course of this webinar, I will definitely be sure to follow up with you to get them answered.

I have entered my email address in the chat box - Lauren.Solkowski@ACO.HHS.gov. So please send me - send your questions to me and I will follow up with you. So again, as the operator mentioned, we are recording the webinar.

And I will be posting the recording, the slides and a transcript of the webinar, online, for your reference, usually within 24 to 48 hours following the webinar. So with that, I would like to introduce and welcome our speaker for today, Tim McNeill.

Tim is an independent healthcare consultant, specializing in health program development and sustainability. Tim, thank you so much for being with us today. And I will turn things over to you.

Tim McNeill: Great. Thank you so much. So today, the second, part is an expansion upon the last presentation in this quality series that was focused more on HEDIS measures. And today we're looking at star ratings, upon which HEDIS is a component of the overall star rating, as it applies to Medicare Advantage plans.

Next slide. So I'm going to give - initially give an overview about what the star ratings program is about, the target population, how to analyze the rating, the star rating data which, from a business acumen standpoint, provides information for an organization to really begin targeting their business contract captures strategy.

And then how to really apply that data to the market data. Next slide. So what are Star measures? So the CMS, the Centers for Medicare and Medicaid Services administers the star rating program, attempting to provide beneficiaries with objective measures to compare plans.

So from a glance, a beneficiary can see if a plan is - has high quality or low quality based on the number of stars. And these stars range from one to five. A five star plan is excellent. A one star plan is poor.

And so a beneficiary that - a Medicare eligible beneficiary, can look at a plan's ratings and make a side by side comparison of other plans in the marketplace, and allow them to choose. Health plan star ratings are publicly available.

And the star ratings program provides incentives to health plans to improve quality - the quality of services rendered to beneficiaries. Next slide.

Lauren Solkowski: Tim, are you there?

Tim McNeill: Oh, sorry.

Lauren Solkowski: Sorry.

Tim McNeill: So the Centers for Medicaid and Medicare Services administers the star rating program specific to Medicare Advantage plans. So if there's a conversation in your marketplace, anything related to star ratings, know that it is directly related to Medicare Advantage plans in the marketplace.

And a Medicare Advantage plan is a type of Medicare health plan offered by a private insurance company that contracts with Medicare to provide all Part A

and Part B benefits. So that also means that all established Part A and Part B benefits under original Medicare are included in a Medicare Advantage plan.

Next slide. So there are four types of Medicare Advantage plans. So there is the traditional HMO where there's a defined network. And beneficiaries that are enrolled in a Medicare Advantage HMO defined plan generally have to stay in that network. As long as they stay in that network their costs are covered.

A PPO plan is one where there's reduced costs to the beneficiary if they stay within network, but they have the option of going out of the network to providers outside of that network.

And there is additional cost to the beneficiary but they have more flexibility under a PPO plan than an HMO plan. And the - what's less common - those are the two most common types of Vantage plans, either an HMO or a PPO.

And a particular type of Medicare Advantage plan or an organization that offers Medicare Advantage plans, can offer more than one type of plan in a particular market. So for example, you may see that Humana offers an HMO plan and they have one defined membership under that HMO plan.

And they have a separate membership under the PPO plan. And both plans can have different star ratings because they may be graded differently in the same market.

And if I'm now making a presentation on - I'm doing my market analysis around where a plan - where they sit in the market, I'm going to look to see what their penetration rate is, which means what is the percentage of Medicare

eligible beneficiaries that enroll in their type of plan, and what that particular plan - how that particular plan rates in terms of star ratings.

And it will be different if that organization has an HMO and has a PPO in the same market. What's less common is the private fee for service plans. And the special needs plans are - you may hear them referred to as CSNP or DSNP plans.

Those are the dual eligible plans, the dual eligible special needs plan and the CSNP is the chronic disease special needs plan. But those are Medicare Advantage plans for a defined target population. Next slide. So as a member of an HMO plan, the beneficiary is limited to the network.

Generally (unintelligible) only receive care from an out of network provider in case of an emergency. What's advantageous to some beneficiaries to select an HMO plan is that they have limited out of cost - out of pocket expenses as long as they stay in network.

And so there's less variation in their potential costs. Next slide. With the PPO plan, the beneficiary has more options but they also may have the potential for more costs.

So a beneficiary with - that has limited income which traditionally you see in the marketplace, is a beneficiary that elects to go into a Medicare Advantage plan that has limited income generally shies away from a PPO plan because of this potential of increased costs to that beneficiary. Next slide.

And private fee for service plan, this is a Medicare Advantage plan that's also offered by a Medicare and private insurance company where there's a predetermined amount that that plan pays to doctors and providers.

And there's also a predetermined amount that the beneficiary must pay when they get care. Also with these private fee for service plans, there's more options but also there's the potential of incurring additional costs if you go outside of the established network that that plan provides. Next slide.

A special needs plan is a type of Medicare Advantage plan that's limited to people with specific diseases or characteristics. So a chronic condition special needs plan is worked that is defined by a condition.

So an example of a chronic condition special needs plan is a Medicare Advantage plan that is serving consumers with HIV in a certain population, say South Florida. So that special needs plan is singly focused on Medicare, eligible beneficiaries with HIV in that defined market.

And that's who they're enrolling. An institutional plan is for Medicare beneficiaries that are in institutional settings like long term care. And a dual eligible plan or a DSNP plan, is focused on dual eligibles in a defined marketplace.

So they don't enroll - if a beneficiary wants to enroll in one of those plans and doesn't meet one of those criteria, a special disease or special characteristic, then they're not eligible to sign up for that specific plan in their market. Next slide.

So what population is eligible for Medicare Advantage plan enrollment? So that is - that's the people that are eligible for Medicare. So in order to be eligible for Medicare you have to be 65 and older or under 65 with certain disabilities, that makes you eligible for Medicare.

Once a beneficiary is deemed eligible for Medicare, then they have the option to remain in original Medicare or elect a Medicare Advantage plan. If they remain in original Medicare then all of the traditional requirements in terms of coinsurance and (Medi-Gap) - those things apply to original Medicare.

Medicare Advantage - a Medicare policy does not apply to a beneficiary that's elected to go into Medicare Advantage.

Because when they made the selection of a Medicare Advantage plan then they opted out of original Medicare for that period of time and allowed a private insurance company to manage their Part A and Part B benefits going forward.

And that there are also certain categories of populations that get assistance if they choose to enroll in a Medicare Advantage plan.

And so there's something called low income subsidy groups so that beneficiaries that are low income receive a subsidy to offset the cost - the premium amount that's required for Medicare Advantage. And that same type of assistance is made available to dual eligibles.

There are some people that qualify for low income subsidy but don't necessarily qualify for dual eligibles. Because in order to qualify for - as a dual eligible, you have to meet the Medicaid eligibility requirements in your particular state.

And there are instances where a beneficiary may not meet the Medicaid eligibility standards in their state but quality for the low income subsidy. And so that's why both groups are identified separately. Next slide.

So on average, about 31% - and this is a slide - this is a - this is based on data from the Kaiser Family Foundation. And they've developed this chart based on their analysis of CMS data. And so they've found that nationwide there's about 31% of the national average of Medicare Advantage enrollment.

And there are some markets where they have much higher penetration of Medicare Advantage and then some markets where there's a very low penetration. But on average, the penetration or enrollment of Medicare Advantage is 31%.

So when looking at working with Medicare Advantage plans and looking at the analysis of the star data, HEDIS data, medical loss ratio data, all of the things that we've been talking about, that applies to roughly 31% of the Medicare Advantage population across the country.

And there are some markets where there's higher enrollment and sort of applies to more beneficiaries, and some markets where it's much lower. Next slide. So what is the overall purpose of the star ratings?

The star ratings provide an objective measure for a consumer to compare health plans as it relates to quality.

And so it - it gives a beneficiary that elects to go into a Medicare Advantage plan, an opportunity to do a side by side comparison of plans - of multiple plans so that - to assist them in making a decision. But also provides a significant incentive for health plans to improve on defined quality measures.

And allows the mechanism of the health plans to meet high quality measures and achieve financial rewards as a result. And a lot of the potential financial rewards drive activity of a Medicare Advantage plan.

And it's - you can assist that Medicare Advantage plan with achieving the goals and requirements they need to achieve to meet the minimum threshold to get the financial rewards. Then you become a value added partner with that Medicare Advantage plan in your market.

And so you value proposition increases when you are able to assist that health plan with meeting these objectives. You want to - need to know what those objectives are; know where that health - particular health plan that you want to contract with, where they sit on that continuum.

And also define very clearly how you could assist that health plan with achieving those objectives. Next slide. So why are Medicare Advantage plans also - one, it's very clear why they're concerned with improving quality and reaching financial objectives.

But they're also very concerned about low star ratings. And so one of the reasons that they're increasingly concerned about low star ratings is that beginning in 2016 Medicare Advantage plans that achieve less than a three star rating for three consecutive years, will be issued a notice of non-renewal.

So essentially their contract will be terminated. Now this is beginning 2016. So remember, if you look at HEDIS measures which is a significant component of the star rating formula - it's not the only component.

But remember, when we look at the HEDIS measures at the last presentation, you can look on the scale and you can see exactly what those HEDIS measures are, where that plan performed as it relates to HEDIS measures, where there were areas of improvement.

And it just so happens that HEDIS measures are also graded on a five - on a level of five stars as well. So five - plans that have a HEDIS measure and they've scored a five, do well. Those that score a one, scored poorly on that specific measure.

And so you see that those health plans increasingly need to improve their performance. Next slide. So why are Medicare Advantage plans really also concerned? This is a key issue and one that's not discussed as much.

I know a lot of times Medicare Advantage talk about the opportunity for them to receive some type of financial reward. But in another key area is their ability to have what's called year round open enrollment. So plans with a five star rating have the advantage of year round enrollment.

And plans with less than a five star rating are limited to the open enrollment period. So a non-five star plan is limited to enrollment only between October 15th and December 7th. Whereas a five star plan has open enrollment all year long. So that is a key driver in the marketplace. Next slide.

So an eligible beneficiary can switch to a five star MA plan one time during - from December 8th to November 30th, which gives them a tremendous advantage. So not only does that Medicare Advantage plan have the opportunity for year round enrollment.

They also have the opportunity to market to beneficiaries that are enrolled in a non-five star plan. And those beneficiaries have the opportunity to opt out of that plan that's not a five star plan, and enroll themselves into a five star plan during the remainder of the year.

So see how open enrollment ends December 7th and the enrollment period for a plan to switch from open enrollment to open - excuse me, to a five star plan, begins immediately after open enrollment closes.

So essentially a five star plan has the opportunity to market, promote themselves and grow their health plan year round. And every health plan that does not, has - they have the threat that a five star plan can market to their members and have those members elect out.

So if you're in a market and it's very easy to see who's a five star plan. Once open enrollment closes, five star plans will have information going year round. And in my community Kaiser is a five star plan and they have this big banner - open enrollment.

And that open enrollment banner never comes down because they're a five star plan and they're all year long enrolling. And it's because they've achieved that five star status. So they want to achieve five star rating and they want to maintain that.

And it's essential for kind of dominance in the marketplace. Next slide. So star (unintelligible) - Medicare Advantage star ratings are calculated based on data from five sources. So HEDIS measures is one component of the five data sources that are used. And each one has its own weight.

So CAHPS scores and (unintelligible) done workaround character efficiency, work with hospitals. You know, you're familiar with CAHPS scores. So it's Consumer Assessment of Healthcare Providers and Systems.

And the way CAHPS scores are calculated is it's a randomized sample of the beneficiaries that are enrolled in a plan and a third party vendor does a

consumer review with a sample set. And then based on that consumer feedback, they're able to then develop the CAHPS score for that plan.

The health outcome survey is another mechanism. Lastly, CMS administrative data; support measures such as call center performance, complaints, beneficiary disenrollment; all those things also reduced, is a factor in star ratings. And last are (unintelligible).

So the aggregate of how a plan performs on each of these things goes into their star rating.

So if you look at this list of items, the one that the health plan has the most means of impacting as well as community based organizations you likely have the most means of impacting directly with HEDIS measures as well as the consumer set where - that's really looking at consumer satisfaction with the delivery system.

Those two items - there's definitely strength in community based programs to help improve those outcomes. Next slide. So star ratings are released once a year - each October before the open enrollment period, star ratings are released.

And they can be found on the Medicare Advantage plan compare Web site. So right at the onset of open enrollment, the beneficiaries have the option of going there and they can specifically look to see how a health plan performed during the previous year and look at those star ratings and what site is there.

Next slide. So when you go to that Web site then you essentially are take - the consumer is brought to this (Splash) page where they can do a general search

and it is by zip code because the Medicare Advantage plan is limited to their assigned market.

And so that Medicare Advantage plan which you put in your zip code, you're provided with a list of plans that cover your market. And from there you are - can see which plan has a five star rating.

You see all the plans are available in your market and it clearly tells you how they fared as it relates to their quality performance for the prior year. Next slide. So there are five domains for star ratings. And this information is also provided on this Web site.

So the Medicare Advantage plans are given the summary star rating, both on their performance and one of five domains. So the use of screening tests is one, management of chronic diseases; the consumer experience, again the CAHPS scores.

Member complaints and customer service appeals. So all of those things go into the makeup of these - of the star ratings. And a consumer can search within a domain to see what the specific star rating was for that health plan.

So given that, if they know that they have multiple chronic conditions, they can go directly to that domain and see how a specific health plan fared as it relates to management of chronic conditions, because that is most attuned to them.

If they have - if their focus is more on member experience, then they can look to see what the specific star rating was for that member experience domain for that health plan.

So all of those that again, give the beneficiary a means of searching how health plans in their markets, are faring on each one of the domains. Next slide.

So I pulled out some of the domains that are scored, to compare them to some of the programs that some of you are doing, to see if there's specific opportunities.

And so some of those are care of older adults, such as a medication review; functional status assessments; reducing the risk of falling; all cause readmissions; care coordination.

So you can begin seeing if you have the capacity to meet these objectives, there are specific HEDIS measures that tie directly to star ratings. And I stated before, there's tremendous incentives for health plans to meet and exceed the requirements for star rating performance. Next slide.

So some health plans have been very vocal about saying that socioeconomic factors impact star ratings. And as a result, CMS has authorized an external analysis on the impact of socioeconomic factors on quality measures.

So they initiated a study to look to see how socioeconomic factors directly impact star ratings. And they looked at two target populations - the population that have a low income, subsidy or LIS. And the population of dual eligibles.

Both groups are looking at those that were in a Medicare Advantage plan to see if there's any statistical evidence to show that there's a direct correlation between socioeconomic status and the achievement of star ratings and quality performance ventures.

And the outcome of the data was mixed. On some performance measures actually consumers that had limited socioeconomic factors actually fared better than the general populations. And on some factors they fared significantly worse.

And so they're issuing additional studies. And so what reason I believe that that's important for them, is that the health plans have stated that they feel as though they have limited ability to address quality performance for consumers that have limited socioeconomic need.

And so much so that CMS has done an initial study and are doing an additional study. So that clearly is a point of pain that the industry at large, has said they need help with.

And so if you have past performance strength and the capacity to assist with that target population, that is a target population that across the board there's been lots of discussions and even studies done really looking at what is the true impact of socioeconomic factors on achieving these performance metrics.

Next slide. So as I said, the preliminary data is mixed. Some factors fared worse, some factors actually fared better. Additional studies will be done. But clearly that is an ongoing issue that's not resolved at this time. Next slide.

So now looking at the actual items that are included in the five domains as I reported. So the first one around staying healthy looked at screenings, tests and vaccines.

So those include breast cancer, colorectal cancer screening, flu vaccine is definitely one that many of you are involved around annually, supporting,

assisting high risk beneficiaries and making sure that they get flu shots. Improving and maintaining mental health.

So things like pearls and other evidence based interventions that are screening for depression. Getting consumers into care that is - directly ties into a (unintelligible) marginal physical activity.

So consumers that - programs that are doing things like enhanced (unintelligible) and other things to their - there is potential alignment with the star rating performance indicators, the programs that community based organizations can do.

One of the challenges that's been an ongoing discussion is how we capture that data; how we document the impact of the programs; how we deliver that clinical data back to the health plan or the physician group so that they can take credit.

Because remember, for - in order for a health plan to achieve the star rating, they have to prove that these things occurred. And as - and that usually occurs through documentation. So we're not able to deliver the data back to the health plan.

Then we've lessened our value to the health plan and meeting that objective measure. Next slide. Managing chronic conditions is a much longer list. So this first one - special needs plans; care management; care of all of adults that their medication reviews.

Care of older adult's pain screenings, functional status assessment, Diabetes care. There's a whole section on Diabetes care. The last one - the last two, reducing the risk of fall.

So that's been increasingly heightened part of the conversation with managed care plans and the next edition is going to be around ACO performance measures. They say there's an ACO performance measure around management of risk of falling, for high risk beneficiaries, as well.

So one that is a cost driver. If consumers are falling it's also a contributing factor to hip replacement surgery and other things, which drive up the cost of care, drive down quality.

So one, community based organizations can support the - an overall fall risk reduction strategy in the community in partnership with healthcare providers. It is absolutely a potential benefit for a Medicare Advantage plan.

And the last item on managing chronic conditions, is looking at all cause readmission. So that's also been an ongoing discussion, especially within a program that's engaged in a community care transition program or working with hospitals.

A lot of conversation around readmissions and looking at readmission penalties that are attributed to hospitals.

But what hasn't been as high in the conversation as looking at how all cause readmissions impact managed Medicare Advantage plans which now also ties directly to star ratings for those (same) plans. Next slide.

So the member experience - this goes right to the CAHPS survey where the consumers are being randomly surveyed to see if they feel how they rate their plan in terms of their ability to get needed care, get an appointment within a timeframe that they feel is satisfactory.

Rating of quality, rating the health plan and also care coordination. So this is really more of a consumer satisfaction survey with these items that is a contributing factor to a star rating. Next slide.

So drug safety and accuracy of drug pricing - this really goes to the drug benefit plan for Medicare Advantage. And if there's reviews of medication there are a few things that I think are key here. One is medication adherence for Diabetes medications.

So we saw there was a Diabetes indicator around prevention. There was a Diabetes indicator around managing chronic long term conditions. And then there's a Diabetes indicator around drug pricing.

So programs, organizations that are working with health systems that have an overall management strategy around Diabetes, there's multiple indicators.

That's why oftentimes, if you meet with a Medicare Advantage plan, they have increasing interest in how they can get assistance in managing and delivering services to Diabetes education programs.

I'm working with one site and they said that the number one referral to their community based Diabetes education program was Kaiser. And Kaiser was really tracking when they had classes.

Well it's no wonder - not just because they want the members to have access to the great education and a great program, but also because there's information provide din those sessions that support and improve adherence with a beneficiary, not only to the medications by having an active engaged consumer that understands the importance of self-management.

They're more likely to adhere to their medications. They're more likely to adhere to prevention and have better outcomes. It drives down their cost of that beneficiary by reducing complications of these. It drives up their quality scores and hopefully can help them to achieve or maintain five star status.

If they maintain five star status now they're open - they have open enrollment all year long. They're open for bonuses. They're dominating their market. There's lots of strategic advantages for a plan to partner with community based organizations.

But one thing that we have to be able to do is if we're assisting them with achieving these objectives we have to document that. We have to be able to provide information to the health plan about the return on investment of our programs. We have to be active and engaged.

Have a referral network, maybe partnering with an ACO or other large health provider in our marketplace to be a referral source for those members, to our programs with an objective of giving data to the referring physicians as well as getting data to the health plan on the outcome of those interventions all (unintelligible).

The other item that's new, fairly new, is the completion rate for a comprehensive medication review. That's the CMR.

And a comprehensive medication review is where a beneficiary has a complete review of all of the medications that they are taking to include their prescribed medication, over the counter medication, herbal medication. It's aggregated.

It's reviewed and then that consumer has a direct, one to one encounter with the clinical pharmacist that we've used all of that information. And then makes adjustments and recommendations as necessary.

So you see now that that is a specific HEDIS measure and - or excuse me, that's a measure that - as it relates to star ratings is also a HEDIS measure. Many health plans are - that did not have full capacity to complete a CMR for the vast majority of the beneficiaries, are ramping those up.

And how a program or if a community based program could develop the capacity to assist in that effort, then you become a value added member, not only by helping that individual beneficiary but also helping that plan achieve that specific measure.

Another question I often get is around well just how many people or how - what percentage of the population does the health plan have to improve upon, in order to get a five star status? Well there used to be a minimum threshold, okay, where plans were notified for each measure.

So they knew where they needed to come in on the continuum to order - in order to get certain star measures in that specific category. Beginning this year, CMS is no longer going to publish that data.

And so the health plan - part of that was because if you give any kind of a threshold then a particular health plan may just work to achieve just that threshold. And once they get to kind of the finish line then they may slack off and not move forward.

By removing that threshold now the health plan just knows they have to get the majority of members. And they won't know if they're at the minimum threshold or not.

So they should have - are having to implement a continual vigilance year round to get as high as possible on every measure because they no longer know what the threshold is going to be for a minimum star rating on any particular measure. Next slide.

So the - kind of how do we begin to analyze the star ratings? So the average star ratings are available for each domain or each category. And a comparison of a health plan in your area by average star rating, provides tangible market data.

So the Centers for Medicare and Medicaid Services for the prior year - they publish what the average star rating was for every category and domain. And now you know what the average was. You can look to see what a particular plan in your market where they scored.

And then you can have a direct comparison in that category with that particular plan, in real time, to see were they below average, were they above average?

And so now if I'm having an opportunity to have a conversation with anyone that's in the quality assurance department of health plan or anyone that's interested in star ratings which they - they all are but there's generally a quality assurance department that's primarily responsible for looking at that and then using roles all the way up to medical director for a health plan.

They know exactly where they fare in the marketplace in comparison for each item. And if we have a targeted intervention that can help them with that then that becomes a more focused conversation. So it's two potential opportunities. One, all of the health plans or the majority - I won't say all.

So the majority of health plans have expressed that they believe socioeconomic factors impact their ability to improve star ratings.

So one, if I know that I have past performance capacity strength in addressing the needs of Medicare beneficiaries that have potential socioeconomic factors that impact their ability to self-manage disease, that's one potential strength for me as it relates to the need or the point of pain that the health plans have expressed.

And now if I know specifically where that health plan scored as a star rating for a specific measure.

And then I - if I know that I have a targeted intervention to address that, then that is where there's a merger of need by the plan, strength of my program, capacity to deliver a service that can address that need, that moves me down the contract continuum much better than I have a great program, here's some evidence based research that says this program is, and I'd like a contract.

That's much more general in a sense. Whereas the prior example I gave pushes us to a targeted group where I know I'm effective and I know you have a point of pain. And this is how I'm going to deliver the service.

Now contract with me to deliver. That is a much better conversation for someone has a need and has money to pay. Next slide. So one potential area

that I'm highlighting as part of this presentation is multiple we can look at, is all cause readmissions.

So there is an all cause readmission measure where we look at 30 day readmissions. In the numerator it's at least one acute readmission for any diagnosis. In the denominator it's - it's all inpatient discharges.

And so with - with the deletion of plan readmission - plan readmissions or things like where there's an initial surgery. And then there's a plan - a second admission to come back and do a second service. Are you also offering (seek) plan readmissions around chemotherapy.

Where a consumer may have breast cancer and often with the cases, they may - they may what's called debulk the tumor or remove the tumor and then bring the consumer back to begin chemotherapy and radiation.

So that would be a situation where we have a definitive treatment plan that includes multiple admissions during a defined period. And so that would be an exclusionary factor for a readmission score. And that person - that particular readmission wouldn't be included in the readmission list.

But all of the other items would definitely be included in an all cause readmission. Next slide. So this - this is a screen shot on the data that you would be - that everyone can pull from the CMS Web site, to tell you exactly what the average star rating is by category.

And so I put this out so you can see how the data is provided. So first - the first column is 2012 and it goes up to 2015. So you can see one, how - and this is a straight average, not a medium score.

So that straight average score is the - so there are some people that are below that average, some people above that average.

But it gives you a way of evaluating a particular health plan by seeing how they compare to the average score and how their performance today matches or compares to the average rating over time, from 2012 to 2015. Next slide.

So the sample now says I looked again at all cause readmissions. And the average star rating, as provided from the CMS Web site and I'm going to show you how to pull this information. For 2012 that star rating was 3.3, 3, 3.5. In 2015 it was also a 3.0.

So now if I have looked at a plan in my market and they've scored a 2, a 1, anything under 3.0, I know they're below average. Okay? So now I have a targeted all cause readmission prevention program.

The cost of that program can attribute directly to the medical loss ratio which is a presentation that we went over earlier. It helps with their HEDIS score. And directly applies to just star performance.

And if I know that they were below the average then that - out - as identified from the onset that they have a point of plan - a point of pain around all cause readmissions. Next slide. So where is this data available? So the Web site link there is where that data is available.

You click on that link and then next slide - that would bring you to this page. And so as you see on this page, there is a listing of things. So if you look at the downloads the first one actually is the research on the impact of socioeconomic status on star ratings.

So you see CMS as a result of feedback from the market of Medicare
Advantage brands, CMS not only completed a study but now they've
published the results of that data and essentially that data's been kind of
inconclusive. And they plan to do additional research.

Not only did they - they - CMS follow through and hear from industry on
what their challenges are, they published the data there.

And so even if the health plan is not sure of the potential impact of star - of
socioeconomic status on star rating, there's data here in this study from CMS
that shows on some factors consumers that have socioeconomic challenges
fare worse and on some they fare better. So overall, it's been inconclusive.

But what's also very important on this link, is you see the arrow there is where
the star rating data is available. Now that is a zip file. You would open that zip
file. You'd go to - there is a CSV file that you would open once you - once
you're able - first you unzip the file.

You'd see a CSV link for the 2015 data. Then you would open up that file and
it would take you to an Excel spreadsheet and you would be - see a listing of
health plans. You'd also see where they fared for every indicator and their
specific star rating in that particular category. Next slide.

So this is screen shot of what that spreadsheet looks like. So you'd see the
middle column - contract name. That's essentially the name of the health plan.
And so that - the health plan would have a listing there. And then they'd have
a rating in each category.

Some of the ones - if a plan - the plan has to have a minimum number of
times. So if they just began as a Medicare Advantage plan this year, then

there's not enough time, not enough data available for it to be analyzed. So it has to be a minimum threshold.

So if you see some that say they're not required or they're too new to assess, that's why. You'll get a new plan. So there - until they have the more history and more members then they're not able to objectively assess that measure. Next slide.

So I took the data and began to sort the data by potential needs. And you see there's - the name of the plan, the type of plan it is and then each of those columns that you see are particular star scores that they've had.

That - since that is in an Excel file, you have the means, the opportunity to select the entire worksheet and to begin to sort. So at the end of the presentation window, you'll see Column AA or AA is right after Column Z.

So that Column AA - what I did as part of our exercise of looking at all cause readmissions, I took the CSV file, converted to an Excel, selected the entire worksheet and then I sorted that worksheet by the columns specific to all cause readmissions, which is the AA file.

I sorted it from lowest to greatest number and it - and then looked - then I color coded it and I said let me see all of the plans that have a one star for all cause readmission. I shaded them in gray. Then I looked at all plans that have a two star rating for all cause readmissions.

Any health plan that's in my market that scores a one or a two, as it relates to all cause readmissions, I know that for that indicator they were clearly below the average threshold across the marketplace.

And now given that their minimum threshold going forward is not going to be published, those - any plan that definitely scored below the average of any health plans are very much interested in this now, they know they have to improve that measure.

And it is clear that these specific plans have more challenges than others in reaching that. And some of the examples here, we see that it's been very vocal by some of the plans that are even on this list, about their challenges with improving the readmission measures.

So see third from the bottom is senior whole health. Well senior whole health is a health plan in Massachusetts and part of the first cohort we have a group of - the first cohort of the business acumen initiative, there was senior whole health who have been very vocal that they have challenges around readmission.

And they have contracted with community bead organizations in Massachusetts, beginning with one of the business acumen initiative partners. And now that's expanded to other committee based programs and area agents or agents in other parts of the state, specifically with senior whole health.

And that correlates exactly with the defined need that's listed by CMS. And that senior whole health scored a two as it relates to the star manager for all cause readmissions.

And they actively have engaged community based organizations to support them in improving that particular measure, by contracting with them and paying a case rate for readmission prevention programs using their care transition programs as the (unintelligible). Next slide.

So some of the tips in terms of really how this data can be usable - or applied in your marketplace. One, obviously looking at low performance plans. That was kind of a given. But even with drilling down further than that, when looking at how plans perform in specific categories.

And then looking at that data file that's - everyone can download - sorting that based on where you have strength. So if my strength is around fall prevention activities then I'm going to look to see which plans fared the worst in terms of fall risk reduction programs in their market.

If I have Diabetes - if my strength is around Diabetes (education) programs, I'm looking to see where those health plans fared in that. If my strength is around a community based medication review intervention I'm looking to see who fared the worst as it relates to that.

I can correlate that directly with what is their - that health plan's penetration rate was in the market. I can look to see how that health plan performs in terms of the medical loss ratio.

And then I'd have a very targeted conversation with them about paying for my prevention program, applying those costs to their medical loss ratio and how my community based program is going to capture the data to help document improvement to attribute - to improving their star measure.

And for that targeted conversation and presentation will help to move the conversation along in terms of a potential contract. It's very clear how you can help provide improvement to the health plan, where they have a defined need.

So now there is a potential opportunity with a health plan. And I see that they have scored, you know, five stars as it relates to Diabetes.

And they - then if my strength is around Diabetes efforts, then the Diabetes self-management efforts, then maybe that's not as large an opportunity because clearly the plan has been performing very well. Most plans have - definitely have areas where they can seek improvement.

But again, because there's not a minimum threshold that's published, everybody's striving to get as high as possible in every category. And so assistance with achieving the maximum possible score in every category, is always a benefit. Next slide.

So what are the areas that you would include as part of your value proposition? Identify the risk that your potential customer has. So the risk - the risk that this customer would have is they have a population of beneficiaries.

And that population of beneficiaries have scored poorly or below average in certain areas as relates to star ratings. What is the penetration of that customer in the marketplace? So the customer will be the managed care plan.

So it doesn't - it doesn't help me if I'm working with a particular health plan and that health plan scored poorly in an area where I have strengths.

But then when I look at the penetration in the marketplace and I see that health plan only has 500 members in my marketplace and their competitor has 10,000, well even if I go through all the steps to secure the contract because the penetration of that health plan is so low in my particular market, then that value of that contract, the potential opportunity of that contract is very low.

And so that would not be the highest priority on my list of strategic opportunities on my marketplace, because there has to be a match between need and market penetration of the health plan and my strengths, to address the needs in order for that to be a real, viable opportunity for me to secure a contract.

What are the types of beneficiaries that are served by that plan? So is this a special needs plan like a senior whole health as a (DSNP) or a dual eligible special needs plan?

So knowing that that's a dual eligible special needs plan, being able to customize my presentation and conversation around there are issues that face a dual eligible population that's particular to that group.

Not only do I have strength in delivering programs, but I have a value added benefit of knowledge awareness of how to impact the health and continuum of a dual eligible population. And that could be documented in my work with the Medicaid program and other things.

So that again speaks to understanding the particular need of the payer in that marketplace. How my services address that customer's risk and what level of access I have for the time (unintelligible). So that can be on the (state).

Many Medicare Advantage plans, as well as the Medicaid Managed Care plans and up, one of the challenges that they all continually voice is that some of the high risk members, those are the highest risk. It's also very difficult to get access to them.

And because not everybody that receives mail from their managed care plan, jumps to open it and respond exactly to what the letter says. So that often does return.

So your ability to be an innovative community based program that has programs that meet the target population where they are, that also works with ACOs and other healthcare providers in the marketplace, to deliver programs and services that target that population, you're one, able to demonstrate your ability to access the target population of consumers that have the highest need.

You show the capacity to deliver the services. And then your ability to help show improvement by documenting the services, and give that health plan information that can be applied directly to help them include their star performance on that measure, become part of the - part and parcel of your value proposition.

You just have a program and you expect to have a program and it's targeted to the needs of that health plan. And I'm able to secure a contract with that health plan. Yes, the health plan needs the assistance and let's give the example of Diabetes.

So they scored poorly. This fictional health plan scored poorly as it relates to Diabetes matches. And I have a strong community based network of Diabetes self-management programs that have shown effective over time.

And now I've contracted with the health plan and I look at that - that health plan has 20,000 lives in my - costs in my service area. It is not the responsibility of the health plan to grow my business. It's my responsibility. I would view the contract with the managed care entity as a license to hunt.

And now I can go and bring in beneficiaries that need the service and be rewarded financially for delivering a service for those beneficiaries, helping those beneficiaries have improved those outcomes and helping the health plan meet their financial objectives.

It's never the health plan's responsibility to send me business. So as you give the example - the same example of the hospital. The hospitals are contracted to be the same health plan. The hospitals never sit back and say great, we have this contract with this large health plan.

And so now all we have to do is sit back and the health plan is going to find the members and tell them to come to me so I can build a health plan and make money. Absolutely not. That contract with a health plan is just a means of being paid by - for delivering (conservative).

But it's completely on me to accept that contract as a business opportunity. And it's then on me to go and grow that business opportunity. So some of you that have participated in CCTP that was some of the realization that you had. Well the hospitals are going to have this risk for readmission penalty.

And we have this agreement. And so we'll wait and they'll find us all the business and send it to us. Absolutely it doesn't - it so does not work that way.

And it does not work that way from the managed care perspective because the managed care entity that's contracting with you, potentially has risk and contracts statewide. And they're looking at a very large population that they have to improve upon.

And so what's happening in your local market and that one case manager that's working with you, is probably working with thousands of other

beneficiaries that all need - have needs. And so yes, you can be a value added partner to help them to have that improvement.

But it's up to you to go and find the beneficiary, deliver the service, show the outcome, then you are a value added member in that continuum of service delivery. Next slide.

So the other part of the value proposition is to determine if there's a subset of the population served by the customer that you particular can impact. And so an example is dual eligible plan, special needs plan.

If I'm looking at contracting with other types of plans that have special markets that they serve and I have strength serving them, how can there be an alignment of needs where I then have a targeted conversation about a subset of the population that that plan is at risk for that I have - I know that I can have impact on.

That's a much better conversation than kind of generally stating that I want to have a contract and I hope that I can - I can provide value towards you, the health plan. Next slide.

So kind of last part of the value proposition is documenting the following - how you're going to reach the population, the services you're going to provide, the effectiveness. You're going to track the return on investment for the customer buying your services.

The customer in this - in this instance is the managed care plan. You're going to need a continuous quality improvement program. And you need to deliver regular data to the customer. And that data for a managed care plan or other entities, the preference is secure electronic transmission of data.

If we're going to say we're going to do this great program, we're going to document everybody that comes and we're going to fax you the list of people that come each day.

That doesn't tell the health plan how you're helping to move the bar as it relates to improving quality of care that ties to their star rating.

And so how can - from their perspective, how can their case managers, their medical director, how are they able to justify the cost of your program given a fact sheet that says here's who attended? Remember, they don't - they don't know your programs well enough.

And they don't track the latest publication of the evidence that shows that this is affected. They're really targeted on how is everything we're doing helping us move towards the meeting our quality objectives as it relates to star ratings? Next slide?

So I've also looked at - so what are the things that should be part of the checklist that you're comparing to go to an MCO in your market? So you'd look at I - you'd have a strong program that aligns closely with star rating performance measures.

And now I want to move and engage a Medicare Advantage plan in my market with the contracts. So the first thing I want to look and see where that Medicare Advantage plan fared in terms of the medical loss ratio.

I want to know what they spent on hospital readmission activities as well as prevention and wellness activities. So well - remember, as part of the medical

loss ratio presentation, you can look specifically to see what a health plan spent on wellness and prevention activities.

You can see what they spent on readmission reduction activities. And you can look to see where they fared in terms of the medical loss ratio. Do you know how that plan performed on the HEDIS measures and star ratings and their performance card that ties to your intervention?

So again, it's a very targeted analysis that link to my strengths in delivering a program to the target population. Next slide. So does that Medicare Advantage plan come - have beneficiaries that admit to the hospital? So I have a contract with the hospital to provide services.

So I have a strong relationship with the hospital in my marketplace. Or I have a strong relationship with an ACO or the provider group. And that same provider group is also working with the Medicare Advantage plan in my same market.

And so what I've increasingly heard from ACOs and hospitals that are also engaging in risk, is that the preferred model that a lot of them have, not all of them, is - is they can align with community based programs where they jointly - the providers, the ACO can go to the payer along with the community based program, and state that that community based program is the preferred provider of prevention and wellness for this target population.

And the provider is going to use that community based program as their referral source. The providers become the referral source to fill those programs. And that helps the ACO. It helps the provider group that are also moving into risk based contracting with these same health plans.

Helps them meet that performance. But it also - it supports the community based organization's value proposition to the health plan because now I've identified that I have a strong program.

The strong program can address the needs of the health plan and it also shows that I will have direct access to the target population because I am aligned (certainly) with the leading providers in my community that are treating that population.

So now if I'm working with the largest provider of Diabetes care and they are going to use my community based program as part of their network of Diabetes education, then that shows the health plan - the Medicare Advantage plan, a very clear line of sight on how you will help them address their need and access the population that's at risk.

So the next item is part of kind of the MCO, Managed Care Organization contract and checklist. That plan had bundled payment contracts with hospitals, other providers that you're working with.

So bundled payment is something that's becoming part of the dialog, part of the lexicon around delivering care services. And hospitals, ACO groups, physician groups are increasingly engaging in bundled payment.

And it - it is something that began as a demonstration (unintelligible) Center for Medicare and Medicaid innovation where there's the bundled payment for care improvement initiative that launched in 2013. And many Medicare Advantage plans are also adopting to move toward bundled payment.

And just recently, very recently I was - I had a conversation with both (unintelligible), Amerigroup and United Healthcare as part of their Medicare

Advantage plans and they - they - all three of them in unison, said they are actively engaging in bundled payment negotiations in those end markets around Medicaid managed care.

So increasingly, bundle payment discussions, negotiations are happening. So if there is a bundled payment because a bundled payment negotiation occurring in the market then it is important for you to be - identify how you can participate in that.

And if their provider group that is aligned with your program is in that negotiation with the managed care plan, then you could potentially carve in your cost as it relates to that bundled payment.

And then there will be, again, the provider assisting you, the community based program with receiving reimbursement from the payer as part of the bundled payment negotiation. Next is our data collection process, HIPAA compliance. That's also very important.

So Lauren, I - I have a messaging saying that - to reconnect. Is every - are you connected?

Lauren Solkowski: I'm still connected. Yep.

Tim McNeill: Okay.

Lauren Solkowski: But I think that was your last - yeah. The next slide is your - just your contact information.

Tim McNeill: Okay. Perfect. So - then we only have 15 minutes. One of the things that I - that there - I pulled the 2015 data from - from that Web site, from CMS where

everything is listed by category and that's how I sorted the data and showed you how to look at readmission numbers.

So all calls readmission star rating scores for health plan. And then put that as part of the presentation. If we can make that file available to everyone, you can really begin looking to see if there's a plan in your market that also the only other thing that I was going to do, is just show you how to sort that file.

But essentially, you select the file, you go to sort and then you will then sort the column that includes the score or the category that aligns with what your program is. So I selected the entire worksheet. I went to sort.

I selected the custom sort and then I asked the Excel file to sort it based on Column AA which was all cause readmission. And I asked it to sort from lowest to highest because my interest is I want to know everybody that has pain as it relates to what I have strength to do.

Which in this hypothetical example, was readmission prevention activity. And everybody that scored at the bottom is going to have the most pain. And then it will lessen as we go up toward the five.

So I first looked at everybody that was a one, then everybody that was a two and then those that are three are still important to me, because they're only marginally affected.

And then remember, one of the things that I pointed out earlier; beginning this year and this is the first year this has taken effect, plans that consistently score a three or lower will be asked to leave the Medicare Advantage program.

So everyone needs to - is really - they don't have a choice. They need to get to four or greater. And only four and five plans are going to survive going forward if - so they have to have this continual strategy on how I'm going to improve my outcomes for the population that I serve.

Lauren Solkowski: So Tim, I have the Excel spreadsheet pulled up. So if you could just - so you said that you selected the entire spreadsheet first. That was the first step. And then you sorted it?

Tim McNeill: Yes, correct. I selected the entire spreadsheet.

Lauren Solkowski: Okay.

Tim McNeill: Then I sorted it. So now I went to custom sort.

Lauren Solkowski: Okay. Where is - I see sort.

Tim McNeill: As you - you select sort and then at the bottom the custom...

Lauren Solkowski: Oh I...

Tim McNeill: ...sort option...

Lauren Solkowski: Okay.

Tim McNeill: ...will come open.

Lauren Solkowski: Okay.

Tim McNeill: And so then you see all of the options there and you want to sort by the category. The category that I chose, because before I did the sort I went across the columns and I looked to see for each indicator, what's the indicator that's of interest to me.

And so for the example, I chose AA is the readmission prevention measure. So I chose that one.

Lauren Solkowski: Got it. And then you did smallest to largest?

Tim McNeill: Then I did smallest to largest. And then it's going to revert and give me everybody that scored the lowest.

Lauren Solkowski: Got it. Okay. I did that. It sorted it.

Tim McNeill: Perfect.

((Crosstalk))

Tim McNeill: Great. So then from that list, we know everybody has pain. Everybody that has pain and if I have strength in addressing that pain then there's a potential opportunity. One thing to also think about - that measure is for the whole market that a health plan is addressing.

So if there is a health plan, I'll give the example like United Healthcare in Florida. So United Healthcare in Florida, they have - they're a dominant health plan in many parts of the state so that readmission score is an aggregate for the state.

So it doesn't mean that their highest priority is my market. It also - but they clearly have an issue in this hypothetical example.

So one - that speaks to do I have strength of a network where we can go to the health plan as a group and we can cover a defined region that's larger than myself, but can align closely with the strength of the Medicare Advantage plan in terms of their penetration rate.

And the more that I can do that the stronger - the more value that I can show the Medicare Advantage plan in meeting their needs.

Lauren Solkowski: Okay. So I'm going to go back to the WebEx because I know there were a couple of questions that came in. So are you ready to take questions now?

Tim McNeill: I - I'm ready.

Lauren Solkowski: Okay, great. Great. Okay. So before I do the ones in the chat, Operator if you could just again, provide us with the instructions for asking the questions over the phone.

Coordinator: Yeah, definitely. If you would like to ask a question, please unmute your phone first, press star 1 and record your name. I do require your name to introduce your question. If you would like to withdraw your question you can press star 2.

But again, to ask a question, please unmute your phone first, press star 1 and record your name. It does take a few moments for questions to come through however, so please standby.

Lauren Solkowski: Thank you. So Tim, the first question in the chat is if a plan has its contract terminated due to a low star rating, can they reapply after a certain time period?

Tim McNeill: So they - they - so this is new. This is a new beginning this year and they have to, for three consecutive years, not perform. And so I don't know if they have an option of renewing at a later time. But they're - with their contract being terminated.

                 If they come back into the program, at a minimum they'd have to - I'd imagine that they'd have to establish that they have a corrective action plan to not have that occur again. But generally what occurs, once your contract is terminated, it's very hard to get back in if you're allowed in at all.

Lauren Solkowski: Okay, great. And then another question - it says what are the data sources to find out if a Medicare Advantage - to find out Medicare Advantage plan expenditures for example, on hospital readmission activities.

Tim McNeill: So that data is available through the medical loss ratio data. So there's - there's a Web site that's managed by the Centers for Medicare and Medicaid Services. So it's again, a link to CMS.

                 And you can pull up a particular plan and you're able to see for the prior year, where they reported their expenditure on quality improvement activity or QIA.

                 And the - one of the categories for quality improvement activity is a separate line item for readmission prevention activities or care transition work. And so you can see exactly what the plan reported, of their expenditure and all of - and their reports have to be certified by a CPA.

So it's not (unintelligible) and it has to be able to withstand an audit. So it's very accurate what that number is. So - so you can find that data there. You can also see what they spent on wellness and health promotion activities during the same time period.

That is a - another separate line item in the medical loss ratio report. But you have to go to that data source to see what they reported on the expenditures. And it's going to - the data is going to be available for the prior year that they were able to report.

Lauren Solkowski: And I believe - didn't - Tim, didn't you do a TIP sheet for us?

Tim McNeill: Oh, that's right. I sure did. I'm glad you reminded me. I forgot about that. There's a TIP sheet on how to - how to find that medical loss ratio data. And what the - well there's a TIP sheet on what medical loss ratio means and yes, I think how to find that information for a particular plan as well.

Lauren Solkowski: Right. So I will - I can direct - I think it's on our - the ACO Web site. So I'll put a link up for - to - so you can access it there and find the TIP sheet. So let's see. Operator, I'm checking back with you to see if we had questions come in on the phone.

Coordinator: Unfortunately no. I'm showing no...

Lauren Solkowski: Okay.

Coordinator: ...no questions in the queue, Lauren.

Lauren Solkowski: Okay. Let's see. We've got one more.

Tim McNeill: So while you're doing that - so one of the things too, is you look at - so anyone that's part of the business acumen group - so if you look at the listing of Medicare Advantage plans and which one has penetration and so forth.

Begin - now we can begin looking to see, of those health plans that are dominant in our market, what's the medical loss ratio that tells me not only where they fared in that 85% medical loss ratio requirement, but exactly what they spent on wellness, health promotion, readmission prevention activity.

And now I can look to see also where they fell in terms of star rating and so I know what they spent in the past. I know how they're performing. And then if I know what my strengths are, that's where there's an alignment and an opportunity to move to contracts. So next - did you find Lauren, more questions/

Lauren Solkowski: I did. So the last question I have is just asking for us to send all of the participants, the path that you used to get to the star ratings, in an email, which we can definitely do that, rather than them having to start going and pull it out of the PowerPoint.

But I, you know, we can definitely send that to everybody.

Tim McNeill: So - oh, so they're - the person asking that question was asking for the links?

Lauren Solkowski: She's - I guess - the part - the piece where you went to how you got to the star ratings. Was it just - is it just that one Web site that you go and...

Tim McNeill: Yeah, that...

Lauren Solkowski: ...put in...

Tim McNeill: That's the main page there.

Lauren Solkowski: Okay.

Tim McNeill: And you can see for the current year - you can also pull prior years and so that's also important. If I'm approaching a plan and I see that consistency maybe over the past three years, they continually - continually scored poorly on a particular measure.

That also addresses one, there's a - there's a need right now and they clearly have not been able to address that need, not only this year nor the prior year. So they need to do something, especially now with this new rule that continual poor performance can put their entire contract in jeopardy.

So you can obtain that on that (Splash) page from CMS. And essentially just - you go to the link, you download the file and then the file that Lauren was manipulating comes up. And then you're able to slice and dice that plan as you need.

I would have open and available to me, the listing, maybe that market analysis report, where we look to see what are the dominant Medicare Advantage plans in our market. And then I know I have at the ready, here's the plans that have the dominant penetration in our market.

And now I can look to see how those particular plans fared in the marketplace, to then move to what's the opportunity (unintelligible).

Lauren Solkowski: Great. And then I - as I'm reading the question, I'm wondering if maybe they were referring to when you were talking about getting to the medical loss ratio component. And I just wanted to clarify that.

You know, the TIP sheet Tim did, lays out, you know, step by step sort of how to, you know, delve down into that information that he was talking about earlier, in terms of the expenditures, the Medicare Advantage plan expenditures. So I will share the link to that TIP sheet that's very specific in pulling that information out. Okay.

Tim McNeill: Perfect. And you should then - I suggest that you look at - if I'm going to develop a strategy in my market, I'm looking at generally the top five - if it's the Medicare Advantage strategy, the top five health plans by penetration are going to be the dominant plans in your market. It usually never goes past five.

Five - probably - the top five plans usually have 80% of the penetration in your particular market. And now if I do an analysis of using the TIP sheet that Lauren is going to provide, that's what - then looking at exactly how those plans on prevention and wellness.

And then can align that with their score. Then you know what your opportunities are.

Lauren Solkowski: Great. At this point I'm showing no further questions in the chat. Operator, have any come in on the phone?

Coordinator: Still no questions in the queue.

Lauren Solkowski: Okay. Well I think since we're just about at 3:30 and I'll do one more quick little reminder. The next webinar is scheduled for Tuesday, October

13th, also at 2:00 eastern time. And this webinar will conclude the - sort of the three part quality series.

And that - the topic of that webinar will be focused on ACO quality measures where we've again invited Tim to come back to present. So let me just check one more time before we go. Okay. I'm not showing any other questions.

So - so again, I will send around the link to Tim's medical - to the TIP sheet, the medical loss ratio TIP sheet. If you would like to access his slides I'm going to be posting them on the MLTSS Web site. If you would like them beforehand just let me know and I'm happy to send a copy to you.

So thank you again to Tim and thank you for - to all of our participants for participating today. And have a great rest of your day.

Coordinator: And that does conclude the call for today. Thank you all for participating. You may disconnect at this time.

END